Myasthenia gravis (MG) is a relatively rare disease but has a unique feature which made it extremely interesting for the community of thoracic surgeons. This feature is a potential of clinical improvement due to thoracic operation including removal of the thymus. For the reasons, which have not been clearly understood, thymectomy affects some immunological processes and may lead to the total recovery of all clinical symptoms of MG. This optimal result of treatment is called a complete remission, not a cure, because the disease can recur after a long asymptomatic period of time and the Acetylocholine-Receptor Antibodies which are the markers of MG can be found in the serum even if the myasthenic patient has no symptoms after thymectomy. Complete remission is the best possible outcome after thymectomy but in some patients there is no improvement or even worsening of symptoms after thymectomy. This is totally unknown why so diverse clinical outcomes - complete remission or deterioration are possible in apparently similar patients undergoing the same procedure. There have been endless discussions among thoracic surgeons and neurologists about the value of thymectomy in the treatment of MG and the way thymectomy should be performed. The answer for the first question was given in 2016 after publication of the report on Randomized Trial of Thymectomy in Myasthenia Gravis, which proved that thymectomy improved clinical outcomes over a 3-year period of follow-up in patients with nonthymomatous myasthenia gravis. The answer for the second question - how to perform thymectomy for MG in the optimal way is even more difficult. There has always been a suspicion that the result of thymectomy was dependent on the surgical technique of the procedure. We still do not have enough data to define what should be the extent of thymectomy for nonthymomatous MG and for MG associated with thymomas. We even do not know if any of the minimally invasive techniques of thymectomy practiced currently are as effective as the maximal thymectomy performed through a complete sternotomy combined with cervicotomy described by Alfred Jaretzki more than four decades ago.

In the light of these considerations the book Minimally Invasive Thymectomy should be received. Readers of this book are provided with the comprehensive collection of descriptions of various techniques of minimally invasive techniques of thymectomy presented by the experienced authors from all around the world. This book provides the most updated state-of-art of the operative treatment of MG. It is my real pleasure and honor to recommend this book to all readers.

However, the number and variety of the presented techniques showed how far we are from complete understanding of the principles of optimal operative treatment of MG and how much is to be done to standardize such technique.

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